



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

CHRONIC PAIN RECOVERY CENTER
25810 OAK RIDGE DRIVE
THE WOODLANDS TX 77380

Respondent Name

TEXAS MUTUAL INSURANCE CO

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-12-1043-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On the dates of June 20, 2011 and August 4, 2011 the Requestor received preauthorization to treat...(claimant). These preauthorization allowed for ten (10) days (80 units) and ten (10) days (80 units), respectively, of interdisciplinary chronic pain management. [Exhibit 1] "80 units of interdisciplinary chronic pain management were tendered unto the claimant between the dates of 7/18/2011 and 8/10/2011. An additional 77.5 units were tendered unto the claimant between the dates of 8/10/2011 and 7/18/2011. [Exhibit 2] "

Amount in Dispute: \$2625.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Texas Mutual preauthorized 20 pain management sessions to be provided between 6/30/11 and 9/30/11. (See requestor's DWC-60 packet.) The requestor provided the sessions on 7/18/11 (1), 7/19 (2), 7/20 (3), 7/21 (4), 7/25 (5), 7/27 (6), 7/28 (7), 8/1 (8), 8/3 (9), 8/4 (10), 8/5 (11), 8/9 (12), 8/10 (13), 8/11 (14), 8/15 (15), 8/16 (16), 8/18 (17), 8/19 (18), 8/23 (19), 8/24 (20), 8/25 (21), 8/26 (22), 8/29 (23), 8/30 (24), and 9/1/11 (25). (Attachment 1)." "Texas Mutual paid 7/18/11, 7/19, 7/2, 7/21, 7/25, 7/27, 7/28, 8/1, 8/3, 8/4, 8/5, 8/9, 8/10, 8/11, 8/15, 8/16, 8/18, 8/19, 8/23, 8/25, and 8/26/11. (Attachment 2) Actually one more was paid than preauthorized." "No further payment is due."

Response Submitted by: Texas Mutual Insurance Co., 6210 E. Hwy. 290, Austin, TX 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 29, 2011 August 30, 2011	Chronic Pain Management Program – CPT Code 97799-CPCA (6.5 hours per day X 2 = 13 hours)	\$812.50/day x 2 = \$1625.00	\$00.00
September 1, 2011	Chronic Pain Management Program – CPT Code 97799-CPCA (8 hours per day)	\$1000.00	\$0.00
TOTAL		\$2625.00	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.308 sets out the procedures for resolving a medical necessity dispute
3. 28 Texas Administrative Code §134.204, Medical Fee Guideline for Workers' Compensation Specific Services. *March 1, 2008, 33 TexReg 626*, sets the reimbursement guidelines for the disputed service.
4. 28 Texas Administrative Code §134.600, requires preauthorized for specific treatments and services The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated October 11, 2011

- CAC-197-Precertification/authorization/notification absent.
- 786-Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.

Explanation of benefits dated November 10, 2011

- CAC-197-Precertification/authorization/notification absent.
- 786-Denied for lack of preauthorization or preauthorization denial in accordance with the network contract.
- CAC-193-Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly.
- 724-No additional payment after a reconsideration of services.

Issues

1. Does the documentation support a network contract exist in this dispute?
2. Did the requestor support position that preauthorization was obtained for the disputed services? Is the requestor entitled to reimbursement?

Findings

1. The respondent denied reimbursement for the disputed services based upon reason code "786-Denied for lack of preauthorization or preauthorization denial in accordance with the network contract". The explanation of benefits does not support that the services were discounted due to a contract; therefore, the disputed services will be reviewed per applicable Division rules and guidelines.
2. The respondent denied reimbursement for the disputed services based upon reason code "CAC-197-Precertification/ authorization/notification absent."

On June 30, 2011, the respondent gave preauthorization approval for chronic pain management 5 x Wk x 2 Wks from June 30, 2011 through August 19, 2011, for a total of 10 sessions.

On August 4, 2011, the respondent gave preauthorization approval for an additional 10 sessions of chronic pain management to be done 5 x Wk x 2 Wks from August 4, 2011 through September 30, 2011.

The respondent states that "Texas Mutual preauthorized 20 pain management sessions to be provided between 6/30/11 and 9/30/11. (See requestor's DWC-60 packet.) The requestor provided the sessions on 7/18/11 (1), 7/19 (2), 7/20 (3), 7/21 (4), 7/25 (5), 7/27 (6), 7/28 (7), 8/1 (8), 8/3 (9), 8/4 (10), 8/5 (11), 8/9 (12), 8/10 (13), 8/11 (14), 8/15 (15), 8/16 (16), 8/18 (17), 8/19 (18), 8/23 (19), 8/24 (20), 8/25 (21), 8/26 (22), 8/29 (23), 8/30 (24), and 9/1/11 (25). (Attachment 1)." The Division finds that the respondent's position is that 20 pain management sessions were preauthorized and therefore 20 calendar days of treatment are reimbursable.

The requestor states that "80 units of interdisciplinary chronic pain management were tendered unto the claimant between the dates of 7/18/2011 and 8/10/2011. An additional 77.5 units were tendered unto the claimant between the dates of 8/10/2011 and 7/18/2011. [Exhibit 2]" The Division finds that the requestor's basis for the dispute is that twenty sessions were preauthorized, and a session constitutes 8 hours; therefore, 160 hours were preauthorized.

The Division reviewed the submitted documentation and finds that the requestor did not submit the preauthorization request report to determine if the requestor defined a session as 8 hours. The preauthorization report does not define the 10 pain management sessions as calendar days. Both parties state in the position summaries that a 20 sessions of pain management program was preauthorized.

The Official Disability Guideline, ODG, refers to a chronic pain management as "Total treatment duration should generally not exceed 20 full-day (160 hours) sessions (or the equivalent in part-day sessions if required by part-time work, transportation, childcare, or comorbidities). ([Sanders, 2005](#)) Treatment duration in excess of 160 hours requires a clear rationale for the specified extension and reasonable goals to be achieved. Longer

durations require individualized care plans explaining why improvements cannot be achieved without an extension as well as evidence of documented improved outcomes from the facility (particularly in terms of the specific outcomes that are to be addressed).”

The Division concludes that preauthorization for a chronic pain management program was obtained for 20 full-day (160 hours) sessions or the equivalent in part-day sessions if required by special circumstances.

A review of the submitted documentation does not document special circumstances for the claimant to attend part-day sessions on additional days; therefore, the Division finds that the requestor has been reimbursed for the 20 preauthorized sessions rendered from July 18, 2011 through August 24, 2011. For dates of service August 29, 2011 through September 1, 2011, the Division concludes that the chronic pain management was not preauthorized. Additional reimbursement is not recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	4/18/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.